STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155241	A. BUILDING 00 B. WING	09/16/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST CREEK VILLAGE	525 E THOMPSON ROAD INDIANAPOLIS, IN46227

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for a Recertification and State Licensure Survey. Survey dates: September 12, 13, 14, 15 16, 2011 Facility number: 000145 Provider number: 155241 AIM number: 100275110 Survey team: Marcy Smith RN TC Leia Alley RN [September 12, 13, 14 & 15, 2011] Patti Allen BSW [September 12, 13, 14 & 15, 2011] Karina Gates Medical Surveyor [September 12, 13, 14 & 15, 2011] Barbara Hughes RN [September 12, 2011] Courtney Mujic RN [September 15 & 16, 2011] Census bed type: SNF/NF: 101 SNF: 20 Total: 121 Census payor type: Medicare: 27 Medicaid: 72 Other: 22	F0000	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation.This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests a desk review in lieu of a Post Survey Review on or after October 16, 2011.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Total: 121 Sample: 24 These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2. Quality review 9/23/11 by Suzanne Williams, RN			

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F0157 SS=D	A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. Based on interview and record review, the facility failed to notify a resident's physician of the decision to transfer the resident to another facility. This affected 1 of 3 residents in a total sample of 24 reviewed for physician notification of a transfer or discharge. (Resident #126)	F0157	Resident #126 no longer resides in facility. Physician was notified on 9/14/2011. Staff Development Coordinator (SDC) or designee will educate nurses on the appropriate reporting and physician notification of change in condition, including discharges on 10/11/2011. All resident discharges will be reviewed	10/16/2011

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	Findings include: The closed clinical record for Resident #126 was reviewed on 9/14/11 at 3:00 p.m. The 9/6/11 9:46 a.m. nursing note indicated there was a note left on desk that res (resident) to be DC (discharged) today, paperwork regarding discharge started. No information, other than this nursing note, could be found in the clinical record indicating Resident #126 was discharged/transferred from the facility and that the physician was notified of a transfer or discharge from the facility. During interview with the DON on 9/15/11 at 10:30 a.m., she indicated Resident #126 was transferred to an assisted living facility on 9/6/11. During interview with RN #4 on 9/15/11 at 10:45 a.m., she indicated LPN #3 told her everything was done regarding the discharge of Resident #126 and to just make sure she goes with her medication and belongings. She indicated she did not call Resident #126's doctor to clarify or inform of the resident's transfer/discharge. During interview with LPN #3 and RN #4 on 9/15/11 at 3:05 p.m. , LPN #3 indicated he was told by someone, didn't		following discharges for proper documentation in clinical meetings, Monday through Friday, by clinical team. A checklist will be used by social services or designee to complete at time of discharge to ensure all necessary actions are completed prior to discharge. The Director of Nursing Services (DNS) or designee will complete a discharge Continuous Quality Improvement (CQI) audit tool weekly x 4, bi-weekly x 2, then monthly x 3 months. The Discharge CQI tool will be reviewed in the monthly Quality Assurance (QA) meeting by the CQI committee. CQI committee includes the Administrator, Director of Nursing Services, Medical Director, and other interdiscplinary department managers. If 95 % threshold is not met, action plan will be developed.	

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	remember who, that paperwork was started for the discharge of Resident #126, but he was not physically at the facility when the resident left. He also indicated he thinks this was a miscommunication between RN #4 and himself. RN #4 indicated she was given a brief overview on transfer/discharge during her orientation. The Charge Nurse Job Specific Orientation curriculum provided by the DON on 9/15/11 at 4:16 p.m. included physician notification of Inter/Intra facility transfers. 3.1-5(a)(4)			

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F0203 SS=D	Before a facility transfers or discharges a resident, the facility must notify the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand; record the reasons in the resident's clinical record; and include in the notice the items described in paragraph (a)(6) of this section. Except when specified in paragraph (a)(5)(ii) of this section, the notice of transfer or discharge required under paragraph (a)(4) of this section must be made by the facility at least 30 days before the resident is transferred or discharged. Notice may be made as soon as practicable before transfer or discharge when the health of individuals in the facility would be endangered under (a)(2)(iv) of this section; the resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (a)(2)(i) of this section; an immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (a)(2)(ii) of this section; or a resident has not resided in the facility for 30 days. The written notice specified in paragraph (a)(4) of this section must include the reason for transfer or discharge; the effective date of transfer or discharge; the location to which the resident is transferred or discharged; a statement that the resident has the right to appeal the action to the State; the name, address and telephone number of the State long term care ombudsman; for nursing facility residents with developmental disabilities, the mailing address and telephone			

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	number of the agency responsible for the protection and advocacy of developmentally disabled individuals established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act; and for nursing facility residents who are mentally ill, the mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals established under the Protection and Advocacy for Mentally Ill Individuals Act. Based on interview and record review, the facility failed to issue a notice of transfer/discharge to a resident prior to the transfer/discharge of a resident to another facility. This affected 1 of 3 residents in a total sample of 24 reviewed for receiving a notice of transfer/discharge. (Resident #126) Findings include: The closed clinical record for Resident #126 was reviewed on 9/14/11 at 3:00 p.m. The 9/6/11 9:46 a.m. nursing note indicated there was a note left on desk that res (resident) to be DC (discharged) today, paperwork regarding discharge started. No information, other than this nursing note, could be found in the clinical record indicating Resident #126 was discharged or transferred from the facility and that a notice of transfer/discharge was given to the	F0203	Resident # 126 no longer resides at facility. Notice of intent to discharge was provided to facility by responsible party of resident, who desired to move closer to family. Resident discharged on 09/06/2011 to a facility that was selected by family. All discharges will be reviewed for proper documentation in clincial meeting, Monday-Friday, by clinical team. A checklist will be used by social service or designee to complete at time of discharge to ensure all necessary actions are completed prior to discharge. SDC or designee will educate nurses on the appropriate reporting and physician notification of change in condition, including discharges on 10/11/2011. The DNS or designee will complete a Discharge CQI audit tool weekly x 4, bi-weekly x 2, then monthly x 3. The Discharge audit tool will be reviewed in monthly QA meeting by the CQI committee. If 95% threshold not met, an action plan will be developed.	10/16/2011

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	resident prior to the transfer of Resident #126 from the facility. During interview with the DON on 9/15/11 at 10:30 a.m., she indicated Resident #126 was transferred to an assisted living facility on 9/6/11. During interview with RN #4 on 9/15/11 at 10:45 a.m., she indicated LPN #3 told her everything was done regarding the discharge of Resident #126 and to just make sure she goes with her medication and belongings. During interview with LPN #3 and RN #4 on 9/15/11 at 3:05 p.m. , LPN #3 indicated he was told by someone, didn't remember who, that paperwork was started for the discharge of Resident #126, but he was not physically at the facility when the resident left. He also indicated he thinks this was a miscommunication between RN #4 and himself. RN #4 indicated she was given a brief overview on transfer/discharge during her orientation. The Charge Nurse Job Specific Orientation curriculum provided by the DON on 9/15/11 at 4:16 p.m. included documentation requirements for Inter/Intra facility transfers.			

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	During interview with the DON on 9/15/11 at 12:10 p.m., she indicated no transfer/discharge notice was given to Resident #126 prior to the resident transferring to an assisted living facility. 3.1-12(a)(9)(A) 3.1-12(a)(9)(B) 3.1-12(a)(9)(C) 3.1-12(a)(9)(E) 3.1-12(a)(9)(F) 3.1-12(a)(9)(G)			
F0283 SS=D	When the facility anticipates discharge a resident must have a discharge summary that includes a recapitulation of the resident's stay; and a final summary of the resident's status to include items in paragraph (b)(2) of this section, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or legal representative. Based on interview and record review, the facility failed to have a discharge summary for a resident who was transferred/discharged from the facility. This affected 1 of 3 residents in a total sample of 24 reviewed for having a discharge summary upon transfer/discharge. (Resident #126) Findings include: The closed clinical record for Resident #126 was reviewed on 9/14/11 at 3:00	F0283	Resident # 126 no longer resides at facility. Facility verified with physician order to discharge on resident to another facility on 9/14/2011. A discharge summary recap was completed by facility designee. All resident discharges will be reviewed following discharges for proper documentation in clinical meetings, Monday through Friday, by clinical team. A checklist will be used by social service or designee to complete at time of discharge to to ensure all necessary actins are completed prior to discharge.	10/16/2011

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	p.m. The 9/6/11 9:46 a.m. nursing note indicated there was a note left on desk that res (resident) to be DC (discharged) today, paperwork regarding discharge started. No information, other than this nursing note, could be found in the clinical record indicating Resident #126 was discharged/transferred from the facility and that a discharge summary was completed for Resident #126. During interview with the DON on 9/15/11 at 10:30 a.m., she indicated Resident #126 was transferred to an assisted living facility on 9/6/11. During interview with RN #4 on 9/15/11 at 10:45 a.m., she indicated LPN #3 told her everything was done regarding the discharge of Resident #126 and to just make sure she goes with her medication and belongings. She indicated she did not complete a discharge summary for Resident #126. During interview with LPN #3 and RN #4 on 9/15/11 at 3:05 p.m. , LPN #3 indicated he was told by someone, didn't remember who, that paperwork was started for the discharge of Resident #126, but he was not physically at the facility when the resident left. He also indicated		SDC will educate nurses on the appropriate reporting and physician notification of change in condition, including discharges on 10/11/2011.Addendum: inservice education provided to nurses include documentation of discharge summaries. The DNS or designee will complete a Discharge CQI audit tool weekly x 4, bi-weekly x 2, then monthly x 3. The Discharge CQI tool will be reviewed in monthly QA meeting by CQI committee. If 95% threshold not met, an action plan will be developed.	

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	he thinks this was a miscommunication between RN #4 and himself. RN #4 indicated she was given a brief overview on transfer/discharge during her orientation. The Charge Nurse Job Specific Orientation curriculum provided by the DON on 9/15/11 at 4:16 p.m. included documentation requirements of Inter/Intra facility transfers. 3.1-36(a)(1) 3.1-36(a)(2)			
F0371 SS=F	The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, interview, and record review, the facility failed to maintain hot food temperatures at or above 140 degrees Fahrenheit when leaving the steam table. This had the potential to affect 116 residents who ate food served from the kitchen of 121 residents residing at the facility. Findings include: During observation of the steam table in the kitchen on 9/12/11 at 1:05 p.m., Cook #5 took the temperature of mashed	F0371	No resident was found to be affected by this alleged deficient practice. SDC or designee will educate staff on facility policy and procedures of food temperatures by 10/16/2011. Food temperatures will be obtained and recorded by dietary staff daily at different times during each meal service. Foods found at improper temperatures will be reheated to 165 degrees or discarded as necessary per policy. Temperature log will be reviewed weekly by dietary manager or designee. The dietary service manager or designee will	10/16/2011

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	potatoes at 124 degrees Fahrenheit and pureed soup at 123 degrees Fahrenheit immediately after the last tray was served. During group interview on 9/14/11 at 11:45 a.m., Resident #92 indicated the hot foods served in the dining room are sometimes cold. During interview with the Consultant of Dietary Services on 9/14/11 at 1:10 p.m., she indicated they have now put interventions in place to maintain the food temperatures such as using shallower pans on the steam table. The Food Temperatures Policy provided by the Executive Director on 9/14/11 at 9:05 a.m. indicated hot foods that are potentially hazardous will leave the kitchen (or steam table) above 140 degrees Fahrenheit. 3.1-21(i)(3)		complete a Dietary CQI tool weekly x 4, bi-weekly x 2, then monthly x 3. The dietary audit tool will be reviewed in the monthly QA meeting by the CQI committee. If 100% threshold not met, an action plan will be developed.	

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F0425 SS=D	The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. Based on observation, interview and record review, the facility failed to ensure bottles of eye drops and vials of insulin were disposed of after expiration for 3 vials of insulin, affecting 2 of 8 residents receiving insulin (Residents #104 and #112) and 1 bottle of eye drops affecting 1 of 5 residents receiving eye drops. (Residents #89) Findings included: During a review of the West Wing back cart on 9/14/11 at 10:30 a.m., with Licensed Practical Nurse (LPN) #2, the following was observed: A vial of Lantus insulin for Resident #112 was opened on 8/2/11.	F0425	Resident #104 Lantus insulin was destroyed by Licensed Nurse (LN). A new vial was ordered from pharmacy, and marked with appropriate open date. Resident #104 Lantus and Humalog insulin were destroyed by LN and new vials obtained by pharmacy, and marked with appropriate open date. Resident #89 Pantanol 0.1% eye drops were destroyed by LN and new bottle was obtained by pharmacy, and marked with appropriate open date. SDC will educate nurses regarding medication storage, expiration dates, and the dating of medications when opened on 10/11/2011. The DNS or designee will complete a Medication Storage CQI audit tool, where medication carts will be checked weekly x 4, then	10/16/2011

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	A vial of Humalog insulin for Resident #112 was opened on 8/15. During a review of the West Wing front cart on 9/14/11 at 11:10 a.m., with LPN #1, the following was observed: A vial of Lantus insulin for Resident #104 was opened on 8/3/11. A bottle of Patanol 0.1% eye drops for Resident #89 was marked as opened on 5/31/11. During an interview with LPN #2 on 9/14/11 at 10:30 a.m., she indicated insulin expired 28 days after the vial was opened. An undated facility policy titled "Drug Expiration Dating," received from the Director of Nursing (DON) on 9/14/11 at 12:00 p.m., indicated eye drops expired 3 months from the date opened. An undated facility policy titled "Maximum Storage Conditions for Insulin Vials," received from the DON on 9/16/11 at 8:30 a.m., indicated insulin expired 28 days after it was opened. 3.1-25(a)		bi-weekly x 2, then monthly x 3 months for expired medications. The Pharmacy consultant will check medication carts for undated/open and expired medications on facility visits, but not less than monthly. Discrepancies will be reported to the DNS for follow up. The medication storage CQI tool will be reviewed in the monthly QA meeting by the CQI committee. If 90% threshold not met, action plan will be developed.	

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F0431 SS=E	The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, interview and record review, the facility failed to ensure bottles of eye drops and a vial of insulin were labeled with open dates for 1 bottle of insulin, affecting 1 of 8 residents receiving insulin (Resident #99) and 4 of 5 residents receiving eye drops.	F0431	Resident #99 Lantus insulin was removed from cart and destroyed by LN. New vial of insulin was ordered from pharmacy. Patanol 0.1% eye drops and artificial tear drops were destroyed by LN and new vials obtained from pharmacy. New medications were marked with appropriate open	10/16/2011

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	155241	A. BUILDING 00 B. WING	09/16/2011

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	(Residents #99, #101, #97, and #90). Findings included: During a review of the West Wing front cart on 9/14/11 at 11:10 a.m., with LPN #1, the following was observed: A vial of Lantus insulin for Resident #99 did not have the date it was opened marked on it. A bottle of Patanol 0.1% eye drops for Resident #99 did not have the open date marked on it. A bottle of Artificial Tears eye drops for Resident #101 did not have the open date marked on it. A bottle of Artificial Tears eye drops for Resident #97 did not have the open date marked on it. A bottle of Refresh liquigel eye drops for Resident #97 did not have the open date marked on it. A bottle of Nevanac 0.1% eye drops for Resident #90 did not have the open date marked on it. During an interview with LPN #1 on 9/14/11 at 11:10 a.m., she indicated they were always supposed to put a date on the bottles of eye drops and insulin when they were opened. An undated facility policy titled "Drug		dates. Resident #101 Artificial tears were destroyed by LN and new bottle obtain by pharmacy, marked with appropriate open date. Resident #97 Artificial tears and Refresh liquigel eye drops were destroyed by LN and new bottles obtained, marked with appropriate open date. Resident #90 Nevanac 0.1% eye drops were destroyed by LN. New bottle obtained by pharmacy and marked with appropriate open date. SDC or designee will educate nursing regarding medication storage, expiration dates and the dating of medications when opened on 10/11/2011. DNS or designee will complete a Medication Storage CQI audit tool, where medication carts will be checked for expired, undated or open medications. Audits will be completed weekly x 4, bi-weekly x 2, then monthly x 3 months. Pharmacy consultant will check medication carts for undated, open and expired medications on facility visits, but no less than monthly. The Medication Storage CQI tools will be reviewed in the monthly QA meeting by CQI committee. If 90% threshold not met, action plan will be developed.	

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	Expiration Dating," received from the Director of Nursing (DON) on 9/14/11 at 12:00 p.m., indicated eye drops expired 3 months from the date opened. An undated facility policy titled "Maximum Storage Conditions for Insulin Vials," received from the DON on 9/16/11 at 8:30 a.m., indicated insulin expired 28 days after it was opened. 3.1-25(o)			
F0514 SS=D	The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. Based on record review and interview, the facility failed to ensure blood pressure assessments prior to giving a blood pressure medication were documented for 1 of 7 residents reviewed for documentation of vital signs in a sample of 24. (Resident #23) Findings included:	F0514	Resident #23s physician was notified. Order was received to discontinue blood pressure checks prior to medication administration due to blood pressures within normal limits. Resident will have blood pressure monitored weekly. A Medication Administration Record (MAR) audit was conducted by LN to ensure residents with physician order to monitor blood pressures	10/16/2011

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	The record of Resident #23 was reviewed on 9/13/11 at 11:30 a.m. Diagnoses for Resident #23 included, but were not limited to, high blood pressure and dementia. A recapitulated physician's order for September 2011, with an original date of 11/11/10, indicated Resident #23 was to receive Lisinopril 10 milligrams (mg) once daily and it should not be given if the resident's systolic blood pressure was less than 100. A review of a July, 2011 Medication Record for Resident #23 indicated the Lisinopril was given, but the resident's blood pressure was not documented, on July 10, 17, 18, 19, 23, 24, 27, 28 and 31, 2011. A review of an August 2011 Medication Record for Resident #23 indicated the Lisinopril was given, but the resident's blood pressure was not documented, on August 12, 13, 16, 18, 19, 21, 26, 29 and 31, 2011. Further information was requested from the Director of Nursing (DON) on 9/13/11 at 6:00 p.m. regarding the blood pressures not documented prior to giving the Lisinopril to Resident #23. On 9/14/11 at 10:45 a.m. she indicated she was not able		were completed as ordered. Appropriate measures taken as indicated. SDC or designee will educate nurses regarding appropriate assessment/documentation prior to medication administration on 10/11/11. Weekly MAR audits will be conducted to ensure residents with orders to monitor blood pressures and other physician orders are completed. Appropriate actions will be taken for records found not in compliance. DNS or designee will review MAR audits and complete a MAR CQI tool, where MARs will be checked weekly x 4, then bi-weekly x 2, then monthly x 3 months. MAR CQI tools will be reviewed in monthly QA meeting by the CQI committee. If 90 % threshold not met, an action plan will be developed.	

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	to find the missing documentation. During an interview with Licensed Practical Nurse #3 on 9/14/11 at 11:00 a.m., he indicated he was often the nurse who gave Resident #23 his Lisinopril. He indicated he always checked the resident's blood pressure prior to giving it and he knows the other nurses did too. He indicated "We just didn't write the blood pressures on the medication record. We should have." 3.1-50(a)(1)			
F9999	State Findings: Personnel: 1. Each facility shall maintain current and accurate personnel records for all employees. The personnel records for all employees shall include the following: (4) Past employment, experience, and education if applicable. This state rule was not met as evidenced by: Based on record review and interview, the facility failed to provide documentation of pre-employment references for 4 of 8	F9999	CNA #6, CNA #7, CNA #8, and LPN #9 will have verified pre-employment and/or references checks completed by 10/16/2011. Activities assistant # 10 will receive required dementia training by 10/16/2011. All employees files of employees hired within the last year, will be audited to ensure pre-employment verification and references were obtained. Files found with references or verification will have education and/or experience verified by SDC or designee. All employees' training records will be audited to ensure employees have received required dementia training by 10/16/2011. SDC or designee will educate payroll clerk on facility	10/16/2011

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	employees reviewed for pre-employment references. (CNA #6, CNA#7, CNA #8, and LPN #9). Findings include: Records were reviewed on 9/15/2011 at 3:30 p.m. indicated no documentation of references checked for CNA #6, CNA #7, and LPN #9, and only one reference checked for CNA #8. An interview with the Administrator on 9/16/2011 at 9:35 a.m. indicated two references are needed for all new employees. She also indicated that for CNA #6, CNA #7, CNA #8, and LPN #9, each had a Personnel and Confidential Employee File Checklist that was not checked off as having two reference checks completed. Review of the Personnel and Confidential Employee File Checklist, provided by the Administrator on 9/16/2011 at 9:35 a.m., indicated a minimum of two references are required to be completed prior to new hire orientation. 3.1-14(q) 2. In addition to the required inservice hours in subsection (l), staff who have		policy regarding pre employment verification by 10/16/2011. A personnel audit checklist will be completed prior to new hire orientation. The checklist will be completed by SDC or designee. SDC or designee will educate all employees on dementia training by 10/16/2011. Dementia training will be added to new employee orientation and facility annual in-service training calendar. SDC or designee will complete a personnel file CQI audit monthly x 4, b-monthly x 2, then quarterly thereafter. SDC or designee will audit new employee files to ensure dementia training is received upon hire. Employee files will be audited monthly x 4, bi-monthly x 2, then quarterly. DNS or designee will review personnel audit tools will be reviewed in the monthly QA meeting by the CQI committee. If threshold not met, action plan will be developed.	

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	regular contact with residents shall have a minimum of 6 hours of dementia-specific training within 6 months of initial employment, or within 30 days for personnel assigned to the Alzheimer's and dementia special care unit, and 3 hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents and to gain understanding of the current standards of care for residents with dementia. This state rule was not met as evidenced by: Based on record review and interview, the facility failed to provide documentation of dementia training for 1 of 19 employees reviewed for dementia training. (Activities Assistant #10). Findings include: Review of the employee personnel files on 9/15/2011 at 3:00 p.m. indicated no documentation of any dementia training for Activities Assistant #10. An interview with the Administrator on 9/16/2011 at 8:40 a.m. indicated she couldn't find any other documentation of dementia inservice completed for this employee.			

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	3.1-14(u)			